

**Application for a Clinical Elective by a Visiting Student
from a U.S. Medical School**

Return to: Rosalind Franklin University of Medicine and Science/
The Chicago Medical School
3333 Green Bay Road
Attention: Sally Venus, Medical Curriculum Office
North Chicago, Illinois 60064
Telephone 847-578-3215
E-mail sally.venus@rosalindfranklin.edu

PART I. (To be completed by the student)

Student's Name _____ Student's School _____

Address _____ Address _____

Phone _____ Phone _____

E-mail _____ Contact Person: _____

TITLE OF ELECTIVE _____

REQUESTED DATES: BEGIN _____ END _____

Student must provide all documentation requested in Section VIII of the Guidelines. Applications will not be processed without all the necessary documents.

PART II. (To be completed by Student's Dean and/or School Designee)

The student named above is enrolled in the _____ year of our Medical School and has our permission to take the above elective. At the conclusion of the elective, an evaluation form, which will be provided by our student, should be completed by the RFUMS/CMS Program Director and sent to:

Name: _____ Signature: _____

Title: _____ Date: _____

PART III. (To be completed by the RFUMS/CMS Program Director)

This request IS approved _____ This request is NOT approved _____

Name: _____ Signature: _____

Title: _____ Date: _____

REPORT TO: _____

DAY/DATE: _____ **TIME:** _____ **PLACE:** _____

PART IV. (To be completed by RFUMS/CMS Registrar upon final approval)

Signature: _____ Date: _____

